

**AUTHORIZATION FOR MEDICATION ADMINISTRATION**

2024-2025

I/we authorize that my/our child be facilitated in accessing the prescription (or non-prescription) medications listed below, for the purpose of self-administering, according to the designated guidelines (EDUCATION CODE SECTION 49423):

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Prescribed medication must be in the original container with the original label affixed to the container.
* Non-prescription/over the counter medication accepted with this form.
* Medication will be kept by school personnel until the student needs/requests to use it.
* Any change in prescription requires a new written order from the Physician prescribing the medication. Verbal/email orders are not accepted.

***Signature of this form releases and holds school personnel harmless from any and all liability for damages or injury resulting directly or indirectly from the presence of the medication in the school or its use by my child.***

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Parent/Guardian Name (PRINT) Parent/Guardian Signature Date

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| --- | --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **TIME** | **START****DATE** | **END****DATE** | **REASON FOR MEDICATION** |
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Physician Name (PRINT) Phone Number Date